Child Fatality Review #08-16
Region 4
King County

This four-month-old Caucasian female's cause of death was determined to be from Sudden Unexpected Infant Death (SUID).

Case Overview

On April 23, 2008, the deceased child's mother fell asleep on a couch with the child on her chest. The child had a cold and had been fussy. The mother has two older children, ages four and two years old, who slept at the other end of the couch. During the night, the four-year-old moved to a position next to his mother. When the mother woke in the morning, the deceased child was unresponsive. A neighbor called 911 and CPR was attempted. The child was declared dead at the scene.

Referral History

On January 29, 2008, a relative reported to Child Protective Services (CPS) intake that the mother was hospitalized for post-partum depression. The mother had thoughts about harming the children and herself. The relative received a phone call indicating the children were at a neighbor's house and that the mother was being hospitalized. The children were placed with relatives in Oregon.

The mother picked up the children and appeared to be under the influence of drugs. The mother did not have any information about receiving follow up services for the depression. The relative was concerned about the safety of the children. The deceased child's father was reportedly verbally and physically abusive to the mother. He used cocaine and supplied drugs to mother. He was also physically abusive to the children. The mother was involved with a domestic violence (DV) program and was not to have contact with the father of the children. However, she allowed him in the home. This referral was screened as information only.

On February 21, 2008, a CPS social worker from Oregon reported to Child Protective Services (CPS) intake that the deceased child's father was not allowed contact with the mother because of past domestic violence (DV). The deceased child's mother allowed the father to see the children, including the deceased child. The father has an extensive criminal history from gang activity to domestic violence for the past two years. He also possessed illegal weapons. There were concerns about the mother's mental health. She had been hospitalized for post-partum depression. The Oregon social worker attempted to contact the family, but was told by relatives they moved to Washington State. The mother moved into a domestic violence shelter but continued to have contact with the father. This referral was screened for Alternate Response.

On April 19, 2008, CPS received a report from the King County Medical Examiner's office that the four-month-old child had died. The mother explained that she had fallen asleep on the couch with the baby on her chest. When she awoke, the child was unresponsive. The baby was declared dead at the scene. This referral was accepted for investigation by CPS. The older children were sent by the mother to stay with relatives.

The medical examiner ruled the cause of death was Sudden Unexpected Infant Death (SUID). The manner of death is undetermined. The assigned CPS worker made collateral contacts with health care and early childhood education providers, as well as the DV advocate. Each provider consistently said that the mother and children were doing well, and that they had no concerns about her ability to raise her children. The investigation was closed as unfounded.

Issues and Recommendations

Issue: Changing a referral accepted for investigation to Information Only - The first referral had been screened for investigation. The supervisor made collateral contacts, and determined the family was residing in Oregon, where CPS was opening a case.

Recommendation: The preferred option would have been to close the case as unable to investigate (family moved out of state). Under the new computer system, FamLink, intakes cannot be changed once sent to a unit for investigation.

Issue: Downgrading the second referral from "accepted for investigation" to "low risk"- The referrer was a CPS worker in the state of Oregon. Although his investigation was unfounded, he still made a referral to CPS in Washington, since the mother and children had returned here. Based on an encouraging collateral call with the mother's DV advocate, intake decided the referral could be downgraded to low risk.

Recommendation: It would have been better to have not downgraded this referral. It was made by a CPS worker. The DV advocate is trained to be very supportive to the mother. While this is good, the advocate's perspective may be just one point of view. The regional program manager will follow up with the intake unit about this referral.

Issue: Screening low risk referrals for disposition - A newly assigned supervisor's duties included reviewing all new referrals. The supervisor was unaware that the low risk referral had remained open to her.

Recommendation: The problem was corrected soon afterward by assigning a social worker who reviews all new low risk referrals. The social worker also meets with the public health nurse (PHN) who manages the Early Family Support Services program. This has worked very well in other offices in Region 4.

Issue: Responding to clients who have suffered severe grief and loss - It was very difficult to engage the mother, she was very hostile toward the social workers, who felt physically threatened by her.

Recommendation: CA should consider providing training to address ways of engaging clients who have suffered the loss of a child, or other trauma.

Issue: Collaboration with DV agencies - It would have been better for all if a staff person from the transitional housing facility had been available to be with the CPS workers and the mother. The workers were unaware that one was available and on call who could have responded. Law enforcement back-up would have been another option, considering the safety issues the workers encountered.

Recommendation: The King County Domestic Violence and Child Maltreatment oversight committee is developing a training plan for CPS and DV shelters, to be provided in the spring of 2009.